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# Competence and risk in older adults: A social work perspective

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## Abstract

In more than 15 years of working with older people, in community settings and in health, one of the more common triggers for social work involvement centred around issues of competency – the capacity of the older person to continue to exercise autonomy and self-determination in any or all facets of his/her life. Social workers operate within defined ethical guidelines, one of which is to recognise and uphold the dignity of the individual and the individual's right to autonomy. However, often there is tension between the twin values of upholding this right to autonomy and the duty of care when working with older people where there is a question of impaired cognition and decision-making capacity. This article explores that tension in terms of the social work response.

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## Introduction

Social work with older adults tends to focus on the relatively small percentage experiencing difficulty. The majority of older people do not require the services of a social worker. In my experience, in more than 15 years of working with elders, one of the most common triggers for social work involvement centred around issues of competency – the capacity of the older person to continue to exercise autonomy and self-determination in any or all facets of his/her life.

Social workers operate within defined ethical guidelines, one of which is to recognise and uphold the dignity of the individual and the individual's right to self-determination. Another recognises the need to ensure care and protection especially where there is a question of incapacity on the part of the client (ANZASW, 2008). Often, when working with elders where there is a question of impaired cognition and decision-making capacity, there is tension between these twin values of upholding the right to autonomy and the need for care.

In this article I wish to explore some of those tensions. With no manual of specific guidelines, social workers must look to the increasing body of knowledge from evidence-based social work and other disciplines – specifically medical and legal – as well as their own experience and reflective practice. When is it right to intervene and perhaps even facilitate the legal loss of autonomy perhaps through the appointment of a welfare guardian and /or property manager, and when is it not? There is seldom a clear or precise moment in a person's

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life when incompetency is clear. Much information-gathering, soul-searching, reflection and consultation with colleagues in health and social services accompanies the process.

I will first explore the concept of competency as it relates to the social work task, and then look at the linked question of risk. Two case examples will illustrate the social work process. It is important to state at the outset that each individual and his/her situation are unique, and thus each social work intervention must be tailor-made. Cultural differences need to be noted in the ways people within cultures make decisions. This article is more specifically applicable to working within an individual paradigm. When working with Maori, social workers must be attentive to differences in the understanding and application of autonomy and decision-making.

## **Competence**

Competence, also called capacity, has been defined by Young (2004) as 'the ability to make an autonomous, informed decision that is consistent with the person's lifestyle and attitudes, and to take the necessary action to put this decision into effect' (p.41). This definition summarises a number of important elements – autonomy and self determination, relevant knowledge, life choices and values, and executive function – all of which are integral to the concept of competence. To be competent a person must understand the information relevant to the decision to be made, be able to manipulate that information in order to make a choice, appreciate the consequences of the choice, and finally be capable of communicating that choice to others (Stewart, Bartlett & Harwood, 2005; Darzins, Molloy & Strang, 2000; Cutter, 1991). In addition to the above, Darzins, et al. state that competent decisions are 'not based on delusional constructs' (p.9).

Competence and the lack of it are, in fact, legal constructs (Darzins, et al., 2000; Markson, Kern, Annas & Glantz, 1995). The standard for competence defines when individuals have the legal capacity to exercise their right to self-determination and when others are legally obliged to respect decisions made by them. Because of its legal function, the authority to set the standard for competence is vested in legal not medical authorities. Although health professionals are asked to testify about competence, they do not determine who is legally incompetent; judges make this determination using legal rather than clinical criteria. The law treats competence as a fact to be decided on evidence.

If all this sounds logical and straightforward, it is anything but in practice. For those working in the clinical arena, competence is very much a clinical question (Slone & Pierini, 1995) and 'clinical situations are fraught with ambiguities that do not yield such determinations easily' (Markson, et al., 1995, p. 726).

## **Presumption of competence**

In our society there is a presumption of competence – people above a certain age are presumed capable of making their own decisions (*Protection of Personal and Property Rights Act*, 1988, 1:5; 3:24). People do not have to prove their competence. Rather, the onus is on the person / society, who alleges incompetence, to prove it. This is parallel to the presumption of innocence. A person does not have to prove innocence – rather evidence to the contrary, evidence of guilt, must be provided. Working with the issues around competency, or lack of,

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it is for the professional, including the social worker, to look for evidence of incompetence not for evidence of competence, which is presumed.

### **Competence as domain and decision specific**

In the past, competence was sometimes thought of as an all or nothing reality – one was either competent or incompetent to make any and all decisions. While the reality of global competence is sometimes true, research and experience indicate that in the majority of situations, competence is a relative concept. It is specific, not global and competency determinations are context dependent (Darzins, et al., 2000; Cutter, 1991).

According to Darzins, et al. (2000), competence is both ‘domain specific and decision specific’ (p.4). The domain or area of competence must be determined as ‘people are more or less competent in different areas of their lives, and decisions have more or less serious consequences’ (Young, 2004, p.42). While a person may be quite competent to make decisions about their living arrangements, they may be deemed incompetent to manage their finances. Within each domain, assessments of a person’s competence should focus on specific decisions necessary for that individual. Decisions within domains range from simple to complex. Someone with moderately severe dementia may be perfectly able to decide what to eat for lunch or what clothes to wear, while lacking competence to decide on a financial investment or medical intervention.

Competence and incompetence are also subject to time issues (Perkins, 2006). Those who have lived with or worked with a person with dementia will know that competence can fluctuate depending on the time of day. ‘Sundowning’ is one manifestation of this fluctuation. If a person’s lucidity fluctuates, it does not automatically mean they are incompetent. If competency fluctuates but their wishes or decisions during competent periods remain consistent over a period of time, then that person may be judged competent. A competency assessment should allow people to perform at their best, including their best time of day.

### **The process of making decisions is important**

In considering competence, the process of making decisions is more important to note than the actual decision made. The focus needs to be on a person’s ability to make and execute choices and decisions rather than on the wisdom or folly of the choices and decisions made. Foolish or irrational decisions are not the prerogative of any one group. According to Brock & Wartman (1990) ‘the vast majority of irrational decisions are made by apparently competent’ people (p.1596) and it is neither our role nor our right to override these decisions. Where incompetence is suspected or alleged, we need to look at the decision-making process and the decision in the light of the person’s own life and value systems.

### **When should a competency assessment be carried out?**

A competency assessment is an intrusion (Darzins, et al., 2000; Silberfield & Fish, 1994) and not something that should be done routinely. Respect for a person’s autonomy is an integral part of social work and questioning a person’s competence can challenge the foundation of a person’s autonomy, liberty and dignity. We must have reasonable grounds to suspect a person is no longer competent before suggesting an assessment (Darzins, et al., 2000). Sev-

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eral factors, which can temporarily affect competence levels, need to be considered. Stress, grief; depression; reversible medical conditions – e.g. acute infections, delirium; auditory and/or visual loss; and educational, cultural and socio-economic background can all make it difficult for clients to respond to certain questions. All of these can be confused with a lack of competence and lead to a premature and/or misdiagnosis of incompetence.

While there is no single marker of diminished capacity, there are indications which social workers can note. These include such things as memory loss; difficulties in communication – both oral and written; lack of mental flexibility or agility – that ability to manipulate or work with information; episodes of disorientation; and problems in calculation. When observed as new developments and especially when in combination, these deserve further attention and assessment.

## **Levels of competence**

How competent does a person have to be to be allowed to make a decision? The threshold for competency should not be set too high. The complexity of the decisions which need to be made and the gravity of the outcomes will vary. The greater the risk, the higher the level of competency required (Perkins, 2002). At times in my work, it seemed that an older person was expected to have quite high levels of competency in order to be allowed to retain even limited autonomy. Why assess someone's ability to write cheques if, for whatever reason, they no longer need to do this. As long as there are supports in place to manage financial affairs, the older person need not be assessed for competency in this area. A colleague recommended a competency assessment, with a view to having an older woman placed in residential care, based on the older woman's potentially unsafe use of a microwave. The microwave had been disabled by the family, as had the electric stove. All meals were provided by family members and no use of either appliance by the woman had been observed. When I asserted that a formal competency assessment was unnecessary, at that time, my commitment to the duty of care was questioned. However, with the support of family, this woman continued to live happily and safely in her own home for another 12 months. A person might be able to agree to a simple medical test or treatment but not be able to understand the complexities of brain/heart surgery. We need to ask what is needed in a particular situation and, if a situation is working, be somewhat hesitant to intervene. We must beware of making mountains out of molehills.

## **Informal and formal assessments**

It can be helpful to think in terms of two stages in an assessment of competency – informal and formal (Silberfield and Fish, 1994). The first stage, which can be done by a social worker, is the informal assessment. This occurs when you have reason to believe there are problems of significant concern to question a person's competence. Some of the indications mentioned earlier can serve as a trigger. However, before embarking on an informal assessment of a person's competence, it is good to consider the following areas:

- Is there an actual problem? Be clear about what this is.
- What, if any, are the risks involved in the current situation?
- Will a formal competency assessment address and help solve the identified problem?
- Is there a less intrusive or voluntary solution which could be tried first?

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- Whose interest(s) would be served by a competency assessment?
  - Do I understand the legislation pertaining to competence? (Silberfield & Fish, 1994).

If there are sufficient triggers to suggest a problem, and risk to the older person and/or others is identified, a formal assessment is indicated. This would be specifically to determine whether the older person is capable of making decisions in that particular domain(s) of his / her life. Such a formal assessment of competence is usually carried out by a psychiatrist or geriatrician, or in some cases by the GP. Darzins, et al. (2000) suggest a very clear process in their six-step capacity assessment process. This involves the assessor:

1. Establishing the presence of a valid trigger;
2. Engaging the person being assessed in the process;
3. Gathering information about the context, choices and their consequences;
4. Ensuring the person has the information necessary about the context, choices and their consequences;
5. Conducting the assessment process;
6. Acting on the results (p.12).

## **Risk**

Risk is an important aspect to consider when assessing competence. Indeed, it is often a perceived risk which prompts a competency assessment. What constitutes risk? To some extent it is relative, what constitutes risk for one person may not for another. Risky behaviour is not in itself evidence of incompetence. If it were, many of us would have been deemed incompetent years ago! Risk can sometimes be seen as intrinsically negative and it could be argued that we have become a risk-averse society. Risk minimisation policies, even departments, are an integral part of organisational life. Some health and social work professionals would wish to eliminate all risk for older people, and decisions are sometimes made on the basis of being risk-free rather than life-enhancing. Risks are however an essential part of life. As social workers we must beware of placing the protective duty over respect for individual rights. In a multi/inter-disciplinary team, other professionals will usually ensure due weight is given to risk factors. As social workers, I believe we have a particular role and responsibility in ensuring that individual autonomy and rights are not ignored in the discussion.

Silberfield & Fish (1994) identify six distinct elements as comprising intolerable risk. I found these useful as a guide when trying to assess risk.

*A change that impairs the ability to protect self, or others, from harm.* Why is it necessary to perform a competency assessment now? What recent changes in a person's life arouse concern? If a person is merely continuing to do something s/he has done for a long time without suffering serious harm, it is probably not appropriate to justify an assessment of competency.

*Evidence of manifest failure.* Have there been concrete instances of failure? Without any, there is less reason to conduct a competency assessment. 'The best evidence of abnormal risk is manifest instances of failure that are distressing to the failing person' (Silberfield & Fish, 1994, p.62).

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*The gravity of the anticipated harm.* The graver the anticipated risk, the more likely it is to be intolerable. The person must be exposed to a level of risk which would negatively impact their life. 'Risks that are of little significance are hardly intolerable and are not grounds for challenging a person's competency' (Silberfield & Fish, 1994, p.63).

*The imminence of the anticipated harm.* There may be steps the person is willing to take to minimise the possibility of harm. 'A risk will generally not be intolerable if it is unlikely to materialize in the actual circumstances of a person's life' (Silberfield & Fish, 1994, p. 63).

*The imposition of risk on others.* Are others at risk of harm? Competent adults can choose to run risks which affect themselves but not risks which could result in harm to others.

*The inability to choose to run a risk.* Is the risk chosen or accidental? 'A competent person chooses to run risks; an incompetent person simply happens to run them' (Silberfield & Fish, 1994, p.65).

Safety is a relative term. Will a person really be safer, i.e. have reduced morbidity and/or mortality, residing in an institutional facility against their will, compared to returning home 'at risk'? Loss of capacity is not a licence for discharge to institutional care (Stewart, Bartlett & Harwood, 2005). An assessment of best interests in someone lacking capacity may well conclude that a 'risky' trial at home should be undertaken, e.g. in someone who was known to be independently minded, a risk taker, or had previously expressed strong opinions against going into care. Each case needs to be decided on its own facts (Stewart et al, 2005). 'The goal of risk assessment is not to place others in a cocoon, but only to make certain that their choices are their own and that they cause no harm to others' (Silberfield & Fish, 1994, p.65).

In assessing risk we must also consider the objectivity of the assessment process. Risk assessments have the potential to be value-laden. Knowing our values – personal and professional – is pre-requisite to not imposing them on others. 'Judgement may be clouded by the powerful combination of the natural desire to protect weak or vulnerable people with the equally natural desire to avoid any personal blame or guilt should these people actually come to harm' (Silberfield & Fish, 1994, p. 64). If emotionally involved, whether family member or health professional, it is more difficult to be objective.

## Scenarios

Two scenarios illustrate the dual social work role of assisting incompetent older people who require help and respecting the rights of older people, including the right of those deemed incompetent, to make those decisions that they are competent to make. Names and some identifying details have been changed. These scenarios were chosen from a number of others, as there were clear differences between myself as a social worker and some colleagues on the interdisciplinary team, regarding our understanding and acceptance of the older person's rights to autonomy and self-determination.

### Don

Don, 70, a widower, lived alone. His daughter, Ann lived adjacent on the same property. Ann requested a needs assessment as she believed Don was no longer safe living at home

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and needed residential care. After the assessment, the assessor brought the situation to a case review for approval for Stage 2 residential care.

Don had a history of alcohol dependence and also suffered from osteoarthritis. Eighteen months previously he had suffered a stroke which left him with mobility difficulties. He used a walking frame, and mobility scooter. He attended a local gym twice weekly, using his mobility scooter. Current services: Home supports – housework and assistance with showering; attended a day centre twice weekly where he enjoyed learning the computer; a neighbour (not family) brought him a hot meal daily. He had a medical alarm, and was visited regularly by an Age Concern visitor. Other services were involved though less regularly. (Not all these details were known at the time of the case review).

Ann's concerns: Don was apparently riding his mobility scooter on a busy main road; bills remained unpaid; he had sold property he owned without consulting her; he was forgetful, and had some short-term memory loss as a result of the stroke, and did not always wear his medical alarm; he had suffered a fall resulting in a head wound for which medical treatment was not sought for 48 hours; he was forgetting to feed the dog. 'He's not managing ... needs to be in a rest home ... I can't cope any longer ...' A rest home had been visited and a room was available. It was almost a 'done deal', and the team were ready to sign off on it, especially concerned about the report of his riding his mobility scooter on a main road.

In my role as social worker for older people, I took very seriously the responsibility to ensure client involvement. It seemed to me that we were hearing everything from the daughter's perspective, and we had not heard Don's voice at all. With some trepidation – sole social worker in a medical environment – I challenged the decision. 'And what of Don, what does he want? ... Has he been deemed incompetent to make decisions?' 'Well, no, but it's very obvious from what the daughter says.'

After some discussion, it was agreed that, before a decision was made, I would do a social assessment of the situation. I wanted to see Don alone, without the daughter present. Don, when I phoned, was articulate and appeared to understand my request to visit the following day.

The following morning a neighbour (the meal provider) phoned me. She stated that Don was worried about my visit as he believed I was coming to 'put him away'. He wanted to cancel the visit, unless she could be there. After confirming this with Don this was agreed.

I arrived at Don's 15 minutes early as I wanted to have some time with him alone. He greeted me by name, was articulate and sociable. He was able to relate the reason for the visit and the events leading up to it. There were some short-term memory deficits apparent and some relatively minor repetition but he initiated conversation and asked pertinent questions. For the most part he was able to follow through on questions and answers and gave consistent explanations for his actions. For example, riding his scooter on the road was true, but not on the main road, only in the small cul-de-sac road where he lived, where the footpaths were very uneven. This was backed up by the neighbour. The 'neglected' dog belonged to Ann. He was accepting of all current support services and very clear that he wished to remain in his own home. He was open to the possibility that sometime in the future he might need to go into care. There was a history of difficult family dynamics.

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With Don's agreement I contacted all of the services currently involved plus his GP. No major concerns were expressed by any of these. I discussed the situation with the geriatrician and it was agreed that there were no major alerts to warrant a full competency assessment. The residential care option was retracted.

When I phoned Ann she was very angry with the outcome and threatened me with legal action should Don have an accident or die. I explained her options for appealing the decision including the process of obtaining Welfare Guardianship and Property Management if she wished to follow that course. She left the area and moved north, returning briefly six months later to initiate another assessment for residential care.

Over the next 12 months I made a number of home visits to Don, some unannounced. He would also telephone me on occasion to report on his status. Contact had been renewed with his son, who visited and was supportive of his remaining at home. Support services continued and 18 months later Don was still living safely and happily in his own home.

The unconscious collusion of the original worker with the daughter led to a loss of objectivity. This in turn resulted in a presumption of Don's incompetence and a magnification of the risks involved in his remaining at home. An uncertainty had assumed the weight of certainty. This scenario highlighted for me the importance of a social work voice in ensuring the rights of the older person to self-determination and autonomy were respected.

### **Sam**

Sam, 69, divorced, had no family locally. A referral from a government agency expressed concern about financial abuse by a woman friend, Jane. There was no medical history available as Sam had apparently not visited a GP for many years. Without his agreement, which he had refused to give, a needs assessment would not happen. When I visited, uninvited, he was very welcoming, somewhat childlike and vulnerable in his openness and eagerness for company. I was struck by his physical appearance. He looked much older than 69, was stooped with pronounced ataxic movement. The house, though sparsely furnished, was clean and tidy. He denied having worries or problems of any kind. It quickly became clear that there were significant word-finding difficulties and this dysphasia made conversation a challenge. Within a relatively short time I noted inconsistencies in his stories about his family, about Jane, time recall and photo identification. When checking out concerns about the type and amount of food in the house, he told me he had 'tins and tins and tins and tins ...' On looking, there were but two small cans of food, some coffee, raw sugar, a half packet of biscuits and a container of margarine. According to Sam, Jane handled all his finances and brought him food daily. He showed no insight into his physical or cognitive condition. He categorically refused medical attention, but expressed delight that I would visit again.

There appeared to be no services apart from Jane, who when I contacted her twice agreed to meet with me, but never showed. Against Sam's wishes, I phoned his son Pete for background information. According to him there was a history of memory decline of approximately five years, and 18 months since mobility problems became obvious. The family were concerned at Jane's involvement. She was known to the family as she and Sam had lived together in Wellington for some time, when there had also been financial concerns. Pete stated that Sam had followed Jane when she moved north.



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For me, as a social worker, Sam met the criteria needed for a formal assessment of competence. Following a case review, a geriatrician and I made a follow-up visit in order to begin the competency assessment process. Sam became very agitated at the start of the MMSE, refused to answer the geriatrician's questions and told him to 'p... off' but then answered the same questions when I put them to him. There were considerable inconsistencies. He had no awareness of the value of money, being unable, for example, to distinguish between 10 cents and \$10. It was clear, on further testing, that he lacked competence in most areas of his life. However, although it appeared that Jane was taking advantage of him financially, to Sam, she was the most important person in his life. To him, she could do no wrong and he did not have the capacity to take on new information which would disprove this. Sam appeared to be happy and content in his situation.

Sam was deemed incompetent to manage his finances and Pete's Enduring Power of Attorney (EPA) was activated. Pete chose to allow the status quo to continue for a while longer while we worked on options. He believed that transfer to residential care would signal the end for his father. Monitoring was put into place with the expectation that EPA for care and welfare would need to be activated before long. This in fact happened sooner than expected as Jane withdrew from the situation and Sam was moved into residential care.

This situation was less clear than the previous scenario. In Sam's case, risks real and potential were present. But these had to be weighed against his consistent and persistent stated preferences, both when he was competent and now, that he wanted to have Jane in his life. Being deemed incompetent meant he lacked the competence to choose to run the risks, but his choices had been made some time previously, presumably while he was competent. Lacking insight and understanding of his situation, and the executive ability to do anything about it, Sam was especially vulnerable to undue influence from others. Yet Jane was his sole local support, she and her family the only day-to-day company he had. She brought him a daily take-away meal and ensured his bills were paid (apart from rent which was taken care of by his son). While he was a virtual prisoner in his flat – he seldom went beyond his front door, never beyond his letter box – Sam appeared content. There did not appear to be any risk posed to others. Having him deemed incompetent of managing his finances, ultimately resulted in the loss of Jane's friendship and support, as questionable as this might be perceived. It almost certainly hastened his entry into residential care. Would it not have been better to leave him where he was happy?

In each of the above scenarios, the social work role was crucial in the assessment of competency and risk, safeguarding client autonomy while ensuring safety. Autonomy had to be weighed against the risks involved – both to the client and others, care juxtaposed with autonomy and self-determination. In the first scenario, I believe I got it right. I am not so sure about the second.

## **Conclusion**

Working with older people, social workers will find themselves confronted by issues of competency and risk. Each situation is unique and requires a tailored response. The majority of older people have other health professionals, e.g. doctors, nurses, occupational therapists and physiotherapists, active in their lives at the time a social worker becomes involved. In my experience, these professionals can be relied on to ensure the dynamic of care is

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given due consideration. While social workers also have a similar duty of care, I believe it is incumbent on us over and above this, to ensure that the dynamic of autonomy receives equal consideration and weight. We cannot remain apart from or sit on the fence on these issues. We must be an integral part of the multi/inter-disciplinary team's weighing up of all aspects of the situation, willing to ask the difficult and sometimes confrontational questions to ensure the client's rights, both to autonomy and to appropriate care, are recognised and respected.

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